Meeting Report

Health Sector Response to HIV/AIDS Among Men Who Have Sex With Men

Report of the Consultation

Hong Kong SAR (China)
18–20 February 2009

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HEALTH SECTOR RESPONSE TO HIV/AIDS AMONG MEN WHO HAVE SEX WITH MEN

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Convened by

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NOTE

The views expressed in this report are those of the participants who attended the Consultation on the "Health sector response to HIV/AIDS among men who have sex with men" and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific, United Nations Development Programme, Joint United Nations Programme on HIV/AIDS and Department of Health, Hong Kong SAR (China) for governments of Member States in the Region and for those who participated in the Consultation on "Health sector response to HIV/AIDS among men who have sex with men" from 18 to 20 February 2009 in Hong Kong SAR (China).

CONTENTS

Keywords:

Acquired immunodeficiency syndrome / HIV infections / Men / Sex / Transsexualism

ACRONYMS AND ABBREVIATIONS

amfAR	The Foundation for AIDS Research
APCOM	Asian Pacific Coalition of Male Sexual Health
ART	antiretroviral therapy
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
DIC	drop-in centre
FHI	Family Health International
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
Hivos	Humanist Institute for Development Cooperation
KHANA	Khmer HIV/AIDS NGO Alliance
Lao PDR	Lao People's Democratic Republic
LGBT	lesbian, gay, bisexual and transgender
M&E	monitoring and evaluation
MSM	men who have sex with men
MSW	male sex worker
NFI	Naz Foundation International
NGO	nongovernmental organization
PEP	post-exposure prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PSN	Purple Sky Network
SAR	Special Administrative Region (of China)
STARHS	serological testing algorithm for recent HIV seroconversion
STI	sexually transmitted infection
TG	transgender (person)
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
VCT	voluntary counselling and testing
WHO	World Health Organization
WPRO	(WHO) Regional Office for the Western Pacific

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EXECUTIVE SUMMARY

In many areas of the Western Pacific Region, the number of HIV cases among MSM has tripled in the past few years. HIV prevalence has reached 2–10% in cities in more than 10 countries, and over 10% in a few. Several promising interventions are under way in the Region, but most are limited in scale. Development and implementation of a response have been impeded by insufficient political commitment, highly prohibitory legal and social environments, limited capacity of implementing partners and service providers, and insufficient resources.

In response to the recommendation of a global consultation on "Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender populations" held in Geneva in September 2008, and the requests for action expressed by Member States, the World Health Organization Regional Office for the Western Pacific (WHO WPRO) took the lead in organizing the first regional consultation on "Health sector response to HIV/AIDS among men who have sex with men" in Hong Kong (China) from 18 to 20 February 2009. The aim of the consultation was to discuss ways of scaling up the health sector response to the emerging HIV epidemic among men who have sex with men (MSM) and transgender persons (TG) in the Western Pacific Region. The specific objectives were related to the use of strategic information, role of advocacy and promotion of a single comprehensive package of services for MSM and TG.

Eighty-five participants from 13 countries attended the Consultation. They represented civil society, governments, international development partners, WHO, the United Nations Development Programme (UNDP) and other international agencies. Participants reviewed the epidemiology of HIV among MSM in the region, present state of health sector responses, need for strategic information, as well as the role of advocacy and policy to facilitate implementation of comprehensive health services for MSM and TG to combat HIV in the Region. They were divided into four groups to discuss key issues and challenges to enhancing the health sector response to HIV/AIDS among MSM and TG in the Region, identify action areas and come up with recommendations in the following areas:

Group 1: Strategic information including gaps, data collection and utilization

Group 2: Comprehensive package of services for MSM, TG and their partners

Group 3: Policy and advocacy at the central level to support the implementation of programmes for MSM, TG and their partners

Group 4: MSM work in China and Hong Kong

The groups recognized the urgent need to scale up access to comprehensive services for MSM and TG in the Region. To achieve this, advocacy for changing the legal and social environment and mobilizing resources is a priority, data collection and analysis need to be harmonized and the capacity of health-care workers strengthened. A set of conclusions and recommendations was agreed on by the participants at the Consultation.

General recommendations

(1) Collect strategic information on MSM and TG.

(2) Collect additional information on the HIV incidence among MSM and TG.

(3) Strengthen and harmonize data collection and analysis, promote sharing of data across countries of the Region and achieve comparability of data among countries.

(4) Strengthen the capacity of health providers to address all conditions related to the sexual health of MSM and TG.

(5) Establish a broad-based, regional MSM and HIV task force to strengthen advocacy initiatives and actively engage the health sector in the response to the HIV epidemic among MSM and TG.

(6) Support the development of cost-effective intervention toolkits for MSM.

(7) Promote an enabling environment to facilitate effective heath sector services and rights-based programming.

(8) Focus targeted interventions on the most vulnerable MSM and TG who are at a higher risk for HIV infection, based on an analysis of the local situation.

(9) Convene a consultation with the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) at the global and national levels to identify technical assistance needs and channels for provision of quality technical assistance.

(10) Evaluate and refine a comprehensive Asia–Pacific package aimed at providing a "continuum of prevention, care, support and treatment for HIV among MSM and TG".

(11) Develop a "highly active intervention (HAI) package" in order to break the chain of transmission.

Specific recommendations for China, including Hong Kong SAR and Macao SAR

(1) Continue to engage civil society in partnerships with government institutions to achieve an enhanced health sector response to the epidemic of HIV among MSM and TG.

(2) Continue to strengthen the quality and accessibility of HIV treatment, testing, care and support services for MSM and TG.

(3) Improve the quality of strategic information, sentinel surveillance and research.

1. INTRODUCTION

Men who have sex with men (MSM) and transgender persons (TG) are disproportionately affected by the HIV epidemic. In Asia, MSM are 19 times more likely to acquire HIV infection than adults in the general population, and in China the odds are 45 times.[1] Compared with the better-known epidemics in western countries, the HIV epidemic among MSM in the Asia–Pacific region takes a different path and form, with huge diversity in male sexual identification and behaviour, and different legal environments and societal attitudes towards male sexuality.

As members of society, MSM and TG deserve no less respect than those in the general population, and should be a part of the overall goal of providing universal access to HIV prevention, treatment and care services. At the international level, several guidance documents have been produced, including the World Health Organization's (WHO's) *Priority interventions*[2] and the Joint United Nations Programme on HIV/AIDS (UNAIDS) *Action Framework: universal access for men who have sex with men and transgender people*.[3]

A global consultation on "Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender populations" was held in Geneva on 15–17 September 2008. The recommendations from the consultation included enhancing surveillance and research, adapting and implementing locally relevant priority interventions, stimulating partnerships and collaborations across governments and civil society, and leading advocacy to other sectors to promote prevention and dispel discrimination against homosexuality. Despite knowledge of what is needed to tackle the epidemic in general, critical gaps still exist in translating the guidance into practice at the local level based on the diverse needs of MSM and TG in the region.

The global consultation also tasked WHO Regional Offices with the responsibility for advocating, disseminating evidence and providing technical assistance to countries to ensure universal access to HIV prevention, treatment and care services for all groups of MSM and TG in their countries. It was suggested that the Regional Offices hold consultations with their Member countries to identify key action areas at both the regional and country levels.

Considering that the Western Pacific Region is one of the areas with the largest numbers of MSM and TG, and in response to the recommendation of the Geneva global consultation and requests from Members States during the past two sessions of the Regional Committee, the WHO Regional Office for the Western Pacific (WPRO) took the lead in organizing the first WHO regional consultation on the "Health sector response to HIV among men who have sex with men". The consultation was held in Hong Kong from 18 to 20 February 2009, and was co-organized by the United Nations Development Programme (UNDP), UNAIDS and the Hong Kong (China) Department of Health, with support from the Secretariat (*see* Annex 1 for the agenda of the consultation).

The Consultation was attended by 85 participants from 13 countries and included government and civil society representatives responsible for MSM work within country-level AIDS programmes, temporary advisers, overseas observers/representatives and local observers. Member States that participated in this consultation included Cambodia, China, Fiji, Hong Kong (China), Japan, the Lao People's Democratic Republic (Lao PDR), Malaysia, Mongolia, New Zealand, Papua New Guinea, the Philippines, Singapore and Viet Nam. A number of representatives from regional and international organizations and agencies also

attended the consultation, including the Asia Pacific Coalition on Male Sexual Health (APCOM), the United States Agency for International Development (USAID), Family Health International (FHI) and the United Nations Educational, Scientific and Cultural Organization (UNESCO). Annex 2 provides a full list of country and overseas participants.

The scope of this consultation was focused on the response of the health sector to HIV. In this context, the health sector is defined as wide-ranging, and encompasses organized public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care); health ministries; nongovernmental organizations (NGOs); community groups; professional organizations; as well as institutions that directly input into the health-care system (e.g. the pharmaceutical industry and teaching institutions).

2. OBJECTIVES OF THE CONSULTATION

The aim of the consultation was to discuss ways of scaling up the health sector response to the emerging HIV epidemic in MSM and TG in the Western Pacific Region. The consultation had three objectives:

(1) To discuss ways by which to improve and strengthen HIV/AIDS strategic information on MSM and TG, and review experiences in the provision of HIV/AIDS services;

(2) To share existing comprehensive packages of interventions for the prevention, treatment, care and support of HIV/AIDS among MSM, TG and their partners; and

(3) To identify key actions and recommendations for follow up at the regional and country levels with regard to:

(a) improving strategic information, including both data collection and data utilization;

(b) providing services for MSM, TG and their partners; and

(c) developing or adapting the existing comprehensive package of interventions.

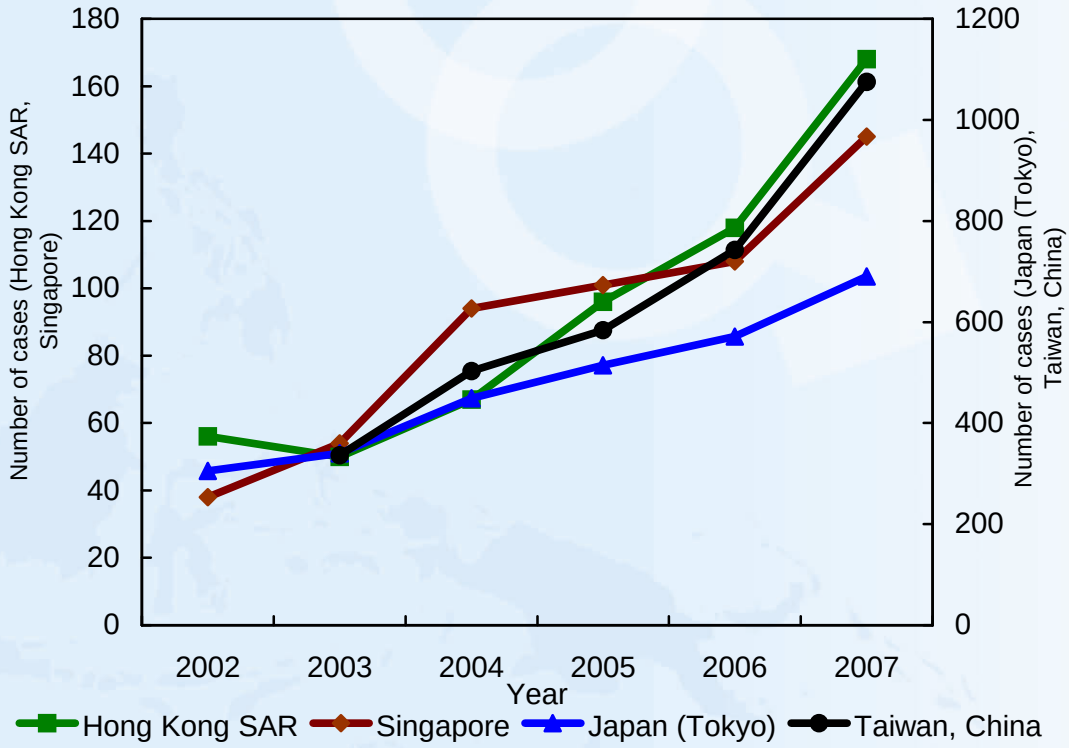
3. HIV/AIDS AMONG MSM AND TG IN THE WESTERN PACIFIC REGION

Evidence shows that an HIV epidemic is emerging across a substantial part of the Region among MSM and TG. As part of the global resurgence of the spread of HIV through unprotected sex between men, the epidemic observed in the Region is made up of interconnected local epidemics that are occurring at different stages of development and vary in their severity. The situation has been recently reviewed and summarized in the *Report of the Commission on AIDS in Asia*[4] and a working paper entitled "HIV and associated risk behaviours among men who have sex with men in the Asia and Pacific Region: implications for policy and programming".[5] On the

first day of the Consultation, the latest epidemiological findings on HIV among MSM and TG in the Region were reviewed. The key findings are summarized below.

A *rapid rise in HIV infections* has been observed in both developed and developing areas in the Region. In some cities including Hong Kong Special Administrative Region (SAR), Japan (Tokyo), Singapore and Taiwan, China, the annual number of HIV infections among MSM has tripled in the past five years (Figure 1).

Figure 1. Number of HIV cases among MSM

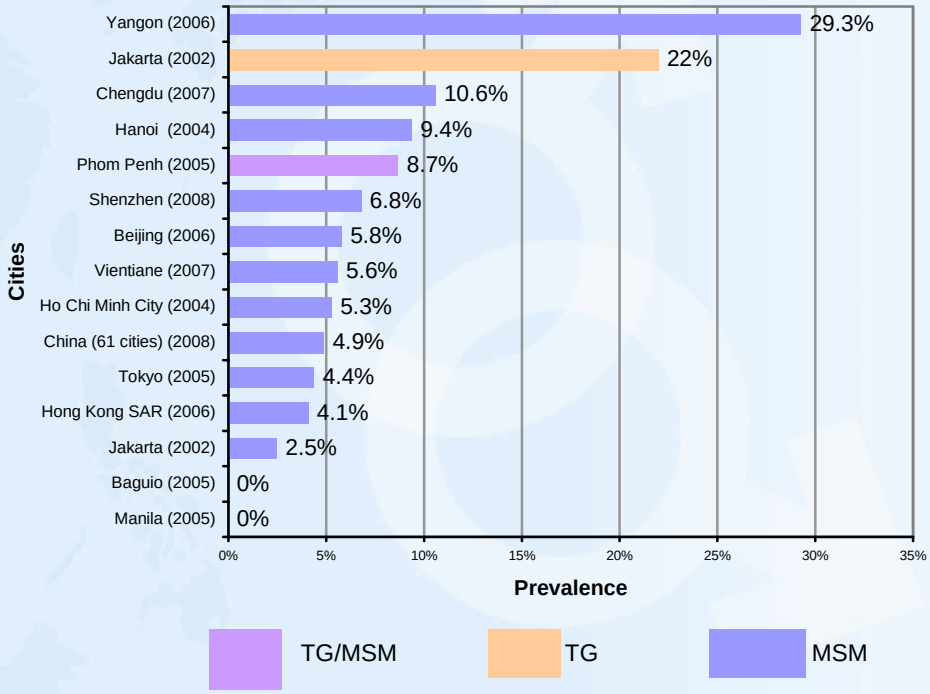


Source: Fritz van Griensven, US CDC (personal communication)

A similar trend was observed in some cities in China where repeated prevalence surveys were conducted. In Beijing and Shenzhen, HIV prevalence among MSM increased from around 1% to 5% between 2004 and 2007 (personal communication, Fritz van Griensven, US CDC), and from 1% to over 10% in Chengdu during the same period (personal communication, Wu Zunyou, CDC China).

The most recent data available suggest that MSM in Cambodia (Phnom Penh) and Myanmar (Yangon) are experiencing severe HIV epidemics with a prevalence of over 10%, and those in Viet Nam (Ho Chi Minh city), Lao PDR (Vientiane), Indonesia (Jakarta), China, Hong Kong SAR and Singapore are experiencing intermediate-level HIV epidemics (HIV prevalence between 2% and 10%). A summary of the latest prevalence data[5,6,7] is shown in Figure 2.

Figure 2. HIV prevalence in MSM and TG in selected cities of the Western Pacfic Region



Australia is unique in the Region as the HIV epidemic among MSM has remained confined to the community for nearly three decades. HIV prevalence has been estimated to be largely stable; in the range of 4–8% in different states.[8] National surveys have shown that approximately 90% of MSM have ever been tested for HIV; about half in the previous six months.[9]

In the Philippines, HIV case reports among MSM have increased fourfold between 2005 (*N*=61) and 2008 (*N*=247). HIV transmission among MSM has superseded heterosexual transmission among the general population to become the most common mode of HIV transmission (67% in 2008). Experts speculate that the HIV epidemic among MSM was imminent, given the high levels of risk behaviour and prevalence of sexually transmitted infections (STIs) (surveys in Manila and Baguio in 2004 showed that 32% of MSM and male sex workers [MSW] tested positive for at least one STI; only 11% and 2% reported consistent condom use, respectively[10]).

Data are severely lacking from the Pacific islands. Given the very different sociocultural context, the social construction and behaviours of MSM and TG in the area are largely unexplored, and the HIV situation is unknown.

There are limited data on the risk factors associated with HIV infection among MSM and TG. In Hong Kong SAR, risk factors such as using the internet for sexual networking and recreational drug use have been identified as factors related to the rapid spread of HIV.

An extremely high HIV prevalence among MSM and TG has been noted in neighbouring areas. For example, HIV prevalence among MSM in Bangkok increased from 17% to 31% between 2003 and 2007, and range from 4% to17% in some areas in India.[11]

There is a clear paucity of data on incidence in the Region. Both case reports and prevalence data are inadequate to inform whether these infections are newly acquired. This knowledge is the most useful in guiding the response to the epidemic, including resource allocation for prevention among different at-risk populations. There are only two studies available from the Region on HIV incidence. One study from Beijing reported an incidence rate of 3.6% with the serological testing algorithm for recent HIV seroconversion (STARHS) assay in 2006,[12] which was higher than the 0.87% reported in Sydney.[13]

In some settings, collection of epidemiological data is hampered by a restrictive legal or policy environment and discriminatory societal attitudes. On many occasions, MSM disguise themselves as heterosexuals at testing and treatment sites, and some choose to avoid accessing testing and treatment in their own country. Under these circumstances, it is difficult to interpret whether the data collected reflect the actual extent of the epidemic.

4. HEALTH SECTOR RESPONSE TO THE HIV/AIDS EPIDEMIC AMONG MSM AND TG IN THE REGION

Some national health departments, national and international NGOs, donors, bilateral institutions and international agencies have focused greater attention on and commitment to addressing and responding to the rapidly increasing spread of HIV among MSM and TG. Several countries have made encouraging progress in the response to the HIV epidemic among MSM and TG, some of which were discussed at the consultation.

4.1 Regional and subregional approach

(1) Asia Pacific Coalition on Male Sexual Health (APCOM)

APCOM was launched in July 2007 with support from the Humanist Institute for Development Cooperation (Hivos), UNDP, UNESCO, UNAIDS and Naz Foundation International (NFI). APCOM is a regional coalition of MSM and HIV community-based organizations (CBOs), the government sector, donors, technical experts and the UN system. Its members include regional, subregional and national networks; and individual MSM and HIV organizations or programmes. The main goals are to increase investment, scale up programmatic coverage and strengthen the evidence base for advocacy of HIV services in the Asia–Pacific. So far, APCOM has functioned as a focal point for communication, technical support and networking. It has facilitated resource mobilization, for example, through employing a subregional approach for development of proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). As an advocacy body, APCOM has been providing inputs to a range of international and policy meetings, and publications.[14]

(2) Purple Sky Network (PSN)

PSN is a collaboration between USAID, US Centers for Disease Control and Prevention (CDC), FHI, US President's Emergency Plan for AIDS Relief (PEPFAR) and the Foundation for AIDS Research (amfAR). It serves six countries in the Greater Mekong Subregion which share a

similar background: limited partnerships, capacity, data and funding for HIV prevention among MSM. The goal of PSN is to reduce the HIV incidence among MSM through strengthening CBOs, improving clinical services and engaging with governments to establish a supportive environment for HIV prevention among MSM. Structurally, it includes networks of country working groups, country focal points, a regional technical board and a coordinating secretariat. Over the years, PSN has arranged annual regional meetings and in-country meetings, regional training activities and published a manual for outreach workers. It illustrates that a subregional approach is practical and can stimulate partnerships and commitment within and between countries.

4.2 National/local experiences

(1) Australia

MSM in Australia were hard hit by the HIV epidemic in the early 1980s. With a supportive and enabling political and legal environment, and provision of free universal health care, Australia has successfully contained and is gradually reversing the epidemic. Key elements of its success include the presence of strong political commitment and full partnership at and across all levels, adoption of a harm minimization policy, and availability of comprehensive and accessible sexual health services. The Albion Street Clinic, started as an HIV testing site, has evolved into an important provider of multidisciplinary health services for gay men. It has been recognized as a WHO Collaborating Centre for providing capacity building to local as well as international health-care workers since 2006.

(2) China

The response in China to the HIV infection among MSM was initially supported by various international agencies: the first hotline targeting MSM was opened in 1997 and by 2002, 20 community groups were set up. Since 2004, the Chinese government has shown commitment to and support for prevention by mobilizing government funding specifically for MSM and formulating its national policy in 2005. It has also recognized the importance of working with MSM and has, till date, held two national consultation meetings with MSM communities to guide policy development. In 2007, it embarked on a national programme involving 61 cities to systematically collect epidemiological information which is then used to inform local prevention and care projects. It is estimated that, at present, HIV interventions reach 70 000 MSM in a month, corresponding to a coverage of 9%.[7]

(3) Hong Kong SAR, China

The response in Hong Kong SAR has been multipronged, focusing on surveillance and research, partnership and collaboration, and resource mobilization within a reasonably supportive environment. Homosexuality was decriminalized in 1991, and discrimination against HIV has been safeguarded by an antidiscrimination regulation. Quality HIV treatment and care is readily accessible at specialized public clinics. Using local data as an advocacy tool, community and financial resources have been mobilized under the framework of Recommended HIV/AIDS Strategies formulated by the Advisory Council on AIDS. The Special Project Fund launched by the Council for the AIDS Trust Fund facilitated the rapid scaling up of HIV prevention activities. Community-based surveillance of the HIV situation, prevalence and programme coverage will be regularized to guide and evaluate response. Technical assistance by overseas experts has played a crucial role in epidemic estimation and capacity building for local workers. Prevention programmes such as risk reduction counselling and STI screening are being incorporated in HIV treatment services.

(4) Shirakaba Clinic, Tokyo, Japan

Opened in October 2007, Shirakaba Clinic is the first lesbian, gay, bisexual and transgender (LGBT) clinic in Japan. It offers a range of comprehensive services including anonymous HIV testing, HIV treatment and psychological support. Feminizing hormones are also available to attract TG. The clinic is characterized by a high level of accessibility, accountability and sensitivity. As a private clinic, it emphasizes strong partnerships with NGOs, hospitals, the government and civil society. Within its first year of operation, the clinic was attended by close to 700 patients, over half of them MSM. It receives funding from the government and pharmaceutical companies. Management of drug-use issues and engagement of high-risk MSM are examples of the challenges that lie ahead.[15]

(5) KHANA, Cambodia

The Khmer HIV/AIDS NGO Alliance (KHANA) was started as a project of the International HIV/AIDS Alliance. It has been operating as an NGO since 1997. It is now a linking organization of the International HIV/AIDS Alliance and plays a key role in supporting local NGOs working with vulnerable communities including MSM. Within the national policy framework, KHANA functions as a source of capacity building for health-care workers at STI clinics and local NGOs, and supports the synthesis of strategic information by participating in size estimation exercises and establishing a monitoring and evaluation (M&E) system for MSM activities. It supports a range of prevention activities including outreach, peer counselling, supporting HIV-positive MSM to access health services, and operating a drop-in centre (DIC) for MSM. It strengthens collaboration with the government through various channels such as arranging consultation meetings to improve the health services. Over 7500 MSM were reached in 2008. Its work now covers seven provinces [16]

(6) The Philippines

MSM have received government attention for HIV prevention activities and have been included in the latest national AIDS policy plan as an at-risk population requiring urgent intervention. The Philippine National AIDS Council, which includes members from six NGOs and two persons from the organization of people living with HIV/AIDS, provides a platform for MSM to participate in the policy-making process. Locally, the Social Hygiene Clinics provide STI diagnosis and treatment, HIV testing and condom distribution. They also provide technical support to local NGOs and outreach services to MSM. The two key challenges are a controversial political position on condom promotion and sustainability of services due to a change in political leadership every few years.

4.3 Experiences from neighbouring countries and international practices

(1) Priority interventions, WHO[2]

These are a complete set of evidence-based interventions recommended by WHO as being necessary to mount an effective and comprehensive health sector response to HIV and AIDS.[2] They include guidance on prioritization according to the epidemiological situation, sociocultural context, health system capacity, and availability of human and financial resources in-country; and the population that is being infected. It is designed as a “living” web-based document that will be periodically updated with new recommendations based on the rapidly evolving experience of scaling up the health sector.

(2) Sexual health approach for MSM and TG

It is recognized that the provision of HIV and STI services alone does not adequately meet the health needs of MSM and TG. Adopting a sexual health framework means acknowledging the rights of MSM and TG to also receive a range of services to meet their special needs. The issues include, inter alia, discussions of relationships, self-esteem, body image, sexual behaviours and practices, spirituality, sexual satisfaction and pleasure, sexual functioning and dysfunction, stigma, discrimination, alcohol and drug use. In addition, MSM and TG may need specific services such as screening for rectal and pharyngeal gonorrhoea and *Chlamydia*, and for viral hepatitis, vaccinations, provision of post-exposure-prophylaxis (PEP) and lubricants, and treatment of oral and rectal infections.

(3) Minimum package of services, Bangkok experience

Bangkok has developed and adopted the Minimum Package of Services for HIV prevention among MSM and TG. It includes five categories of interventions – peer and outreach education, free distribution of condoms and lubricants, use of targeted media, STI screening and treatment, and voluntary HIV testing. Coverage data have been collected through national surveys. In 2007, the coverage of interventions ranged from 27% for VCT to 94% for targeted media. Only 11% of MSM received all five categories of services. Those who received more than one intervention reported less frequent risk behaviour, illustrating that diverse interventions such as the internet, structural interventions and MSM-friendly health services are essential to increase coverage, particularly for hidden MSM. The internet, particularly gay or encounter sites, is being considered as a key new approach due to its importance in networking and promotion of casual sexual encounters.

5. SUMMARY OF WORKING GROUP SESSIONS

On the second day of the consultation, participants were divided into four working groups to discuss key issues and concerns, and challenges to enhancing the health sector response to HIV/AIDS among MSM and TG in the Region. The groups identified action areas necessary for strengthening the response through strategic collection and use of information, advocacy for a supportive environment and promotion of a single comprehensive package of services for MSM and TG.

5.1 Group 1: Strategic information including gaps, data collection and utilization

Group 1 recognized that strategic information is crucial for countries to effectively respond to the HIV epidemic.

Recommendations of Group 1

Data collection, interpretation and dissemination

- The process should be transparent and integrated into existing systems as much as possible.

- Information needs to be disseminated in a timely manner to the appropriate audience and in a suitable and comprehensible format.
- This should involve partnerships among civil society, public health departments and academia.

Major categories of information

- Biological and epidemiological data are required to accurately assess the burden of and trends in the HIV epidemic among MSM; these include HIV case reports, cross-sectional biobehavioural surveys and, ideally, incidence data.
- Social and anthropological data are required to understand the sociocultural context in which male-to-male sex occurs. Examples of such types of data include attitude surveys and ethnographic studies on male sexuality.
- Operations data are required to inform programming and to track progress and evaluate the effectiveness of programme delivery. These include population size estimations, response mapping, project evaluation (formative, process, outcome and impact) and programme coverage assessment.

For the above to be implemented, the following are needed:

- A regional sharing platform
- Agreed guidelines and standards for collection of each type of data
- Increased funding for social and operations research
- Capacity building for health systems and partner agencies to participate in such research.

5.2 Group 2: Comprehensive package of services for MSM, TG and their partners

Group 2 recognized that the needs of MSM and TG are different form those of other clients and these should be addressed through the provision of appropriate HIV and STI services that are available across the spectrum of prevention, care, treatment and support.

Group 2 felt that no single service suits all MSM and TG. Establishing specific MSM/TG clinics, including “boutique clinics” in some areas, could serve as an entry point for MSM and TG to access services. This would augment the response to the special needs of MSM and TG. It can also function as a source of training and technical assistance to other health-care workers. On the other hand, if appropriate MSM services are available and accessible at “general” STI clinics, then the need for a specific clinic may diminish.

Recommendations

A *comprehensive service package* for MSM and TG should include:

- Free distribution of condoms and lubricants
- Outreach projects and operation of DICs
- Targeted media campaigns, including promotion through the internet
- HIV and sexual health services that include

  - HIV counselling, testing and treatment
  - STI screening and treatment
  - Screening and treatment for genital and anorectal problems
  - Hepatitis B testing and vaccination (hepatitis A vaccination optional)
  - Hepatitis C testing
  - Hormonal management and monitoring for TG

- Services for HIV-positive MSM and TG
- Treatment for HIV, including the treatment of opportunistic infections (OIs), provision of antiretroviral treatment (ART) and monitoring of CD4 counts and HIV viral load together with adherence
- Prevention services such as
  - Family planning for female partners
  - Care, counselling and testing for serodiscordant couples
  - Psychosexual counselling
  - Psychosocial counselling, including substance use issues

Group 2 also highlighted that specific sexual health services should be tailored to the local needs and capacity, and emphasized the need for linkages to other clinical and social services. These specialized services should be provided in tandem with capacity-building activities of other health-care workers, e.g. in private settings.

To implement the above, the following supportive activities are essential:

- Capacity building for health-care workers, CBOs
- Mobilization by CBOs of their target community
- Advocacy
- Strategic planning

Where HIV prevalence has reached a certain high level, the measures above would be insufficient to reduce HIV transmission. In such cases, the response needs to be very aggressive in terms of focus and intensity to effectively control the spread of HIV. Group 2 recommended that highly active interventions be implemented in such cases, which may include the following:

- Increased uptake of testing using an “opt-out” approach while maintaining the voluntary nature of the test and confidentiality
- Pre- and post-exposure prophylaxis
- Structural or institutional interventions to support rapid behavioural changes, e.g. regulating the mandatory provision of free condoms and lubricants in sex establishments

5.3 Group 3: Policy and advocacy at the central level to support the implementation of programmes for MSM, TG and their partners

Group 3 identified a wide range of laws and policies that hinder or facilitate work on HIV in the Region.

Laws and policies hindering HIV work

- Laws against sodomy
- Public Assembly Laws (Myanmar)
- Wilful transmission (Fiji)
- Soliciting sex work (Malaysia, Fiji)
- Public Indecency Act targeting transgenders (Malaysia)
- Loitering/Public Nuisance Act (Fiji, India)
- Trafficking laws (Cambodia)

Laws and policies facilitating HIV work

- Antidiscrimination laws related to HIV (Hong Kong)
- Decriminalization of homosexuality (Hong Kong)

Recommendations for a supportive legal and regulatory environment

- A regional meeting of high-level government representatives and UN agencies to discuss the need for laws and policy reforms, and institutionalize the process of ensuring that MSM and HIV issues are addressed by all governments
- A regional task force to follow up issues related to building and strengthening advocacy partnerships across the Region
- A thorough review to properly understand the impact of laws on HIV prevention among MSM, and identify laws and regulations that need to be modified. Advocacy materials are necessary to debunk myths about MSM, especially with religious leaders.

To advocate for *resource mobilization*, Group 3 underscored the importance of programme funding rather than short-term project funding, and the pivotal role of multilateral advocacy with donors and governments.

Recommendations for resource mobilization

- Hold a meeting with donors and UN agencies to ensure inclusion of MSM in programme plans in the Region.
- Hold in-country meetings of donors.
- Develop an advocacy toolkit and a tool for costing and cost–benefit analysis of interventions.
- Engage with large private donors such as the Bill and Melinda Gates Foundation.

Group 3 also recommended developing the capacity of civil society to enable them to engage with or have access to those in power.

5.4 Group 4: MSM work in China and Hong Kong

Group 4 reviewed the current situation, gaps in services and actions necessary to scale up prevention efforts for MSM and TG. They highlighted the synergistic effects of a combination

of political commitment, resource mobilization, multisectoral partnerships, a pragmatic approach and strategic use of information in expanding the response to the rising number of HIV infections in recent years. They also underscored the limited capacity of CBOs and health-care settings to scale up and sustain prevention efforts at an appropriate level of coverage, as well as the resources required to achieve this.

Recommendations for scaling up HIV prevention among MSM

The following issues should be addressed:

- Quality improvement in expanded voluntary counselling and testing (VCT) sites
- Enhancing the sensitivities and skills of health-care workers working with MSM
- M&E of interventions
- Capacity building and securing resources and opportunities to ensure the sustainability and development of CBOs
- Implementing measures to address stigma and discrimination towards MSM.

In addition, Group 4 recommended sharing of local experiences with those who may benefit from these.

6. HIGHLIGHTS AND KEY MESSAGES

There is a clear indication that a widespread HIV epidemic transmitted through sex between men is occurring in the Region. Responses to the epidemic from countries in the Region have so far been varied in terms of political commitment, intensity and scale.

Successful interventions in the Region are being implemented with the help of strong political commitment and ownership, active partnerships between governments and civil society, and substantive participation of MSM and, increasingly, TG. Nonetheless, it is estimated that programme coverage for MSM is only 5% in Asia,[4] which clearly indicates that the scale of the response is far from satisfactory.

The consequences of having services that are unavailable, inaccessible or unacceptable are a continuation of high-risk sexual behaviour among MSM, low level of accurate knowledge of HIV status among MSM resulting in HIV-infected MSM who do not know their status and who do not adhere to appropriate treatment and risk reduction measures even if they know their status. HIV incidence thus continues to rise through the sexual networks of MSM in the Region. Some issues related to enhancing the accessibility and acceptability of services for MSM and TG and recommendations for these were discussed during this consultation, and are given in Annex 3.

It is clear that the *highly prohibitory legal framework* including, but not limited to, sodomy laws, is a critical impediment towards implementing services for MSM and TG. Sex between men is not illegal in only five Asian countries.[5] In some countries of the Region, sex between men is punishable by death or lifelong imprisonment, and meetings between five or more people from civil society (including five or more MSM) are illegal (e.g. Myanmar). Such laws lead to MSM and TG becoming “invisible” and marginalized; their needs are unheard and implementing appropriate services becomes impossible.

In many countries, the *sensitivities and capacity of health-care workers* are also insufficient to address the diverse needs of MSM and TG. This is recognized to be an important factor limiting the access of MSM and TG to appropriate STI, HIV testing and treatment services.

Across the Region, there is a varying level of *political commitment* in the battle against HIV among MSM and TG. Effecting structural changes to the legal and social environment and mobilizing resources are particularly challenging in settings with little government ownership.

Lack of information, resources and capacity are challenges that occur in a vicious cycle. In some areas such as the Pacific Islands, lack of information on MSM has almost excluded them from any discussion, let alone efforts to secure resources for the prevention of HIV among these highly invisible members of society. In all settings, the lack of resources and capacity to sustain a response with adequate coverage are constant challenges.

Universal access to a comprehensive package of services that span the prevention, treatment and care continuum has been repeatedly emphasized as the ultimate goal. There is evidence to show that a combination of peer outreach programmes, management and treatment of STIs, access to condoms and lubricants, and a supportive environment are vital components of an effective response against the HIV epidemic among MSM and TG. Implementing diversified interventions help in reaching out to MSM with different background and needs.

Modelling studies suggest that a coverage level of 80% is required to reverse the trend of the epidemic. Some progress has been made in a few settings; in China, the coverage recorded in 2007 was 9%. Much more needs to be done to scale up the response.

Given the rise in incidence of the HIV epidemic among MSM and TG across the Region, there is an urgent need to put in place interventions at an appropriate scale and intensity. Gaps in knowledge should not deter the implementation of these interventions. It is unethical to not save lives when what needs to be done is known.

Figure 3 summarizes the key factors that influence an effective response to the HIV epidemic among MSM and TG in the Region, and the consequences of inaction. Figure 4 summarizes some of the country profiles of the Region.

Figure 3. Factors influencing an effective response to the HIV epidemic among MSM and TG, and the consequences of inaction

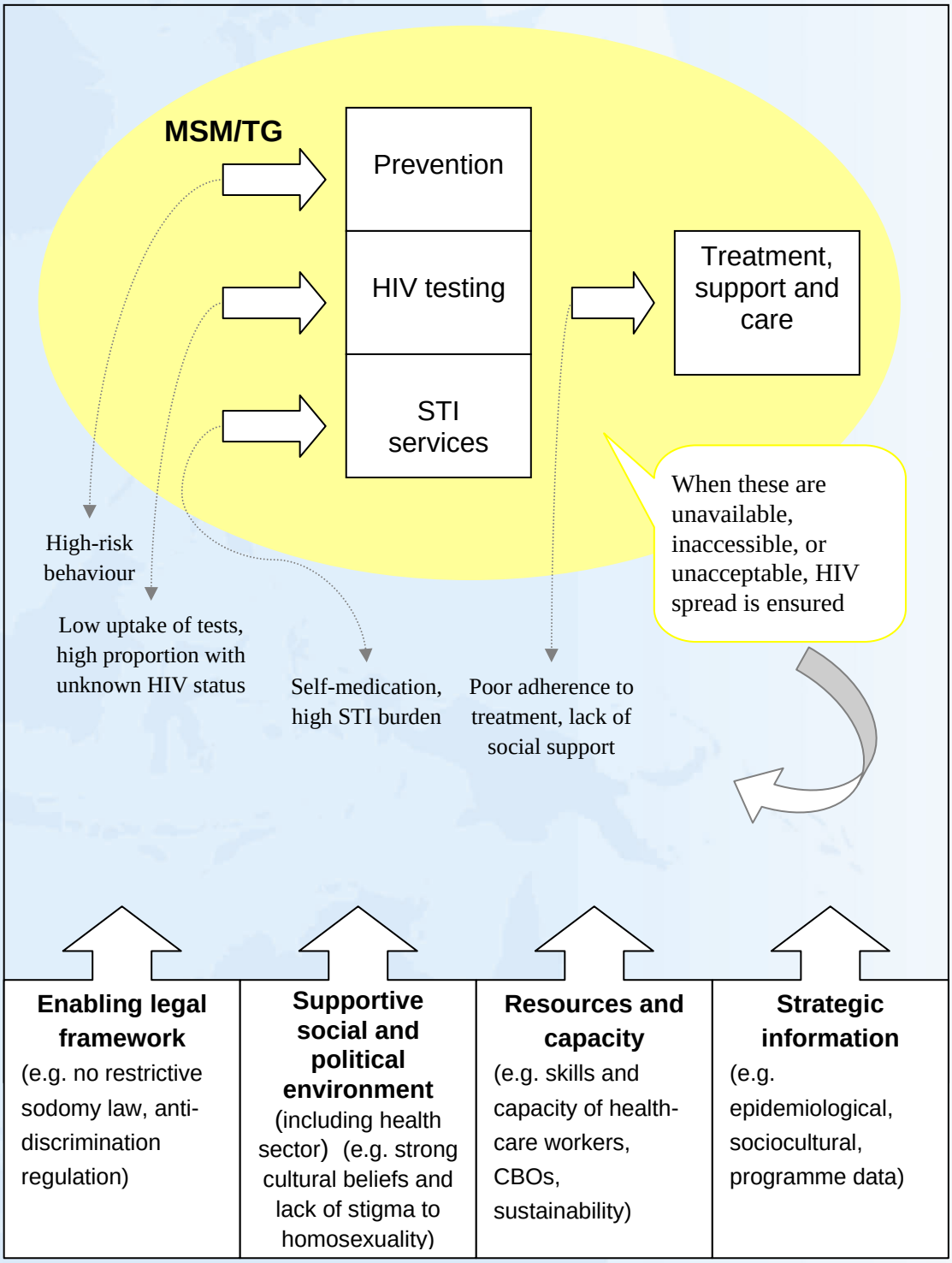
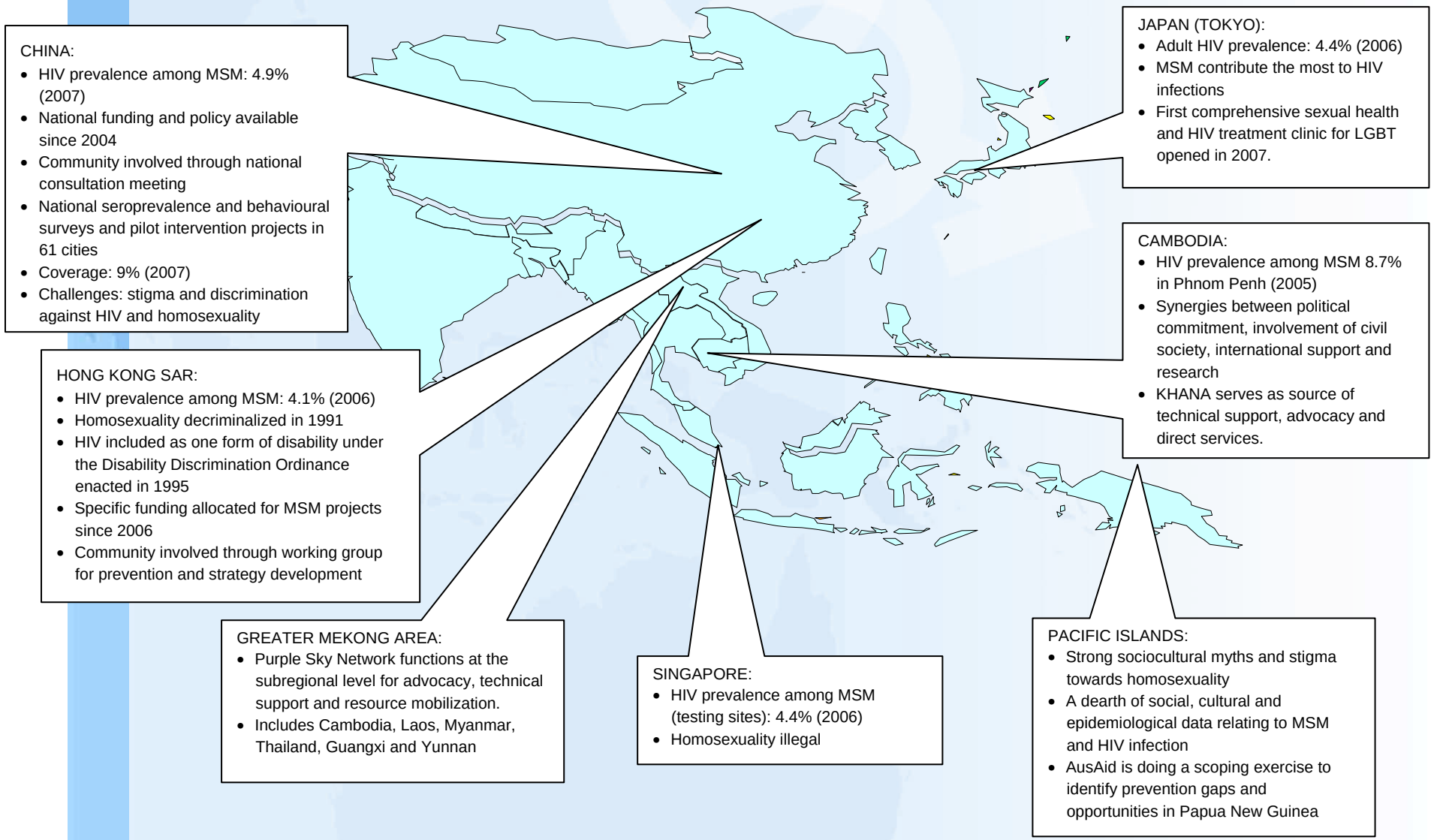


Figure 4. Selected reports from the Region on response to the HIV epidemic among MSM



7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

(1) Despite the paucity of information and several knowledge gaps, available data clearly indicate widespread HIV transmission throughout the Region; MSM and TG appear increasingly and disproportionally affected by the HIV epidemic.

(2) In resource-constrained settings, many national institutions in the Region have limited capacity and resources to generate, collect, analyse and effectively utilize data and information to inform programme planning, allocate resources and conduct advocacy initiatives.

(3) Several countries in the Region still have highly prohibitive legal frameworks regarding same-sex sexual practices and gender norms, which inhibit effective and sustainable responses to the HIV epidemic among MSM and TG.

(4) Full participation of civil society – especially representatives from MSM and TG networks – in the design, planning, implementation and evaluation of interventions is critical, but it is often confronted with restrictive legal and social environments, contributing to further marginalization and "invisibility" of MSM and TG.

(5) The lack of capacity and willingness of many health service providers to identify, assess and manage issues related to the sexual health of MSM and TG, including same-sex behaviours, is recognized to be a severely limiting factor.

(6) However, some national health departments, national and international NGOs, donors, bilateral institutions, and international agencies have demonstrated increasing attention and commitment to addressing and responding to the rapidly increasing spread of HIV among MSM and TG.

(7) Successful interventions in the Region are being implemented in a framework of promotion and protection of human rights; they rely on strong political commitment and ownership, active partnerships between the government and civil society, and the substantive participation of MSM and, increasingly, TG.

(8) Several promising interventions are currently under way in low- and middle-income countries of the Region, but most are limited in scale and coverage. They are constrained by accessibility, quality of services, capacity of implementing partners and service providers, availability of resources, and legal and social barriers.

(9) A comprehensive package of services is understood in different ways with regard to terms such as "minimum", "comprehensive", "essential". However, the consultation recognized the need for endorsing a single comprehensive regional reference package to better inform national responses.

(10) In addition to the comprehensive package, the implementation of a "highly active" range of interventions was recommended for settings with a high HIV prevalence and incidence among MSM and TG.

(11) As the evidence base for some of the interventions included in the packages is lacking or incomplete, there is an urgent need for additional research on and evaluation of interventions in the Region.

7.2 Recommendations

7.2.1 General recommendations

(1) Strategic information on MSM and TG, including epidemiological and biological/behavioural surveillance data, should be collected through existing systems; together with social/anthropological and operations research.

(2) Additional information is needed on the HIV incidence among MSM and TG.

(3) There is a need to strengthen and harmonize data collection and analysis, promote sharing of data across countries of the Region and achieve comparability of data among countries. UN agencies together with APCOM and other partners could assist.

(4) Strengthening the capacity of health providers to address all conditions related to the sexual health of MSM and TG, including same-sex behaviours, is critical for scaling up provision of health services for the prevention and care of HIV among them. The availability of centres of excellence which are better resourced could assist in providing guidance, supervision and capacity building.

(5) Establishing a broad-based, regional MSM and HIV task force would help to strengthen advocacy initiatives and actively engage the health sector in the response to the HIV epidemic among MSM and TG. To operationalize the task force, a permanent standing committee could be created under the umbrella of APCOM to facilitate broader partnerships with technical experts, donors, governments, civil society and UN agencies.

(6) Support should be offered for promoting the development of cost-effective intervention toolkits for MSM.

(7) Opportunities to promote enabling environments need to identified, building upon the outcomes of this consultation. Subregional and national consultations could be held to define and promote an enabling policy environment, and address issues relating to legal, cultural and regulatory frameworks that would facilitate effective heath sector services and rights-based programming.

(8) In order to prioritize the allocation of limited resources and maximize impact, targeted interventions should primarily focus on the most vulnerable MSM and TG who are at a higher risk for HIV infection, based on an analysis of the local situation.

(9) A consultation with the Global Fund should be convened at the global and national levels to identify technical assistance needs and channels for provision of quality technical assistance to ensure optimal utilization of existing resources allocated for MSM in their national responses where resources are scarce.

(10) Evaluation and refinement of a comprehensive Asia–Pacific package aimed at providing a “continuum of prevention, care, support and treatment for HIV among MSM and TG” should be accelerated through research.

(11) In high HIV-incidence settings, additional prevention measures are urgently needed and a “highly active intervention (HAI) package” should be developed in order to break the chain of transmission.

7.2.2 Specific recommendations for China, including Hong Kong SAR and Macao SAR

(1) Continue to engage civil society in partnerships with government institutions to enhance the health sector response to the epidemic of HIV among MSM and TG.

(2) Continue to strengthen the quality and accessibility of HIV treatment, testing, care and support services for MSM and TG.

(3) Improve the quality of strategic information, sentinel surveillance and research.

REFERENCES

The information on Beijing and Shenzhen was presented by Dr Fritz van Griensven, US CDC in a personal communication to the meeting; the figures from Chengdu were taken from Dr Wu Zunyou's presentation (CDC China), who also presented the data as a personal communication to the meeting.

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ANNEX 1

AGENDA OF THE CONSULTATION

Day 1 – Wednesday, 18 February

08:30–09:00	Registration	
09:00–09:45	Welcome	Master of Ceremonies
	Opening Session	
	• WHO	Massimo Ghidinelli
	• UNDP/UNAIDS	Edmund Settle
	• APCOM	Shivananda Khan
	• Secretary for Food and Health, Government of Hong Kong (China)	York Chow
	• Director of Health, Hong Kong (China)	Py Lam
09:45–10:10	*Coffee/Tea break*	
10:10–10:30	**Introduction to the meeting**	
	• Introduction of participants	Massimo Ghidinelli
	• Selection of chairpersons	
	• Objectives and expected outcomes	
10:30–12:30	**HIV/AIDS strategic information concerning MSM and transgender (TG) populations**	
	• MSM – the global epidemiology and response	Ying-Ru Lo
	• HIV among MSM and TG in Asia and the Pacific	Frits van Griensven
	• The Report of the Commission on AIDS in Asia and its findings on MSM and TG	Edmund Settle
	Questions and answers	
12:30–14:00	*Lunch break*	
14:00–15:30	**Experiences in the provision of HIV/AIDS and STI services to MSM, TG and their partners**	
	• China: assessment and response	Wu Zunyou

	• HIV/STI services to MSM in Japan in the private sector	Ichiro Itoda
	• Australian experience on MSM management	Tim Barnes/ Michael Buggy
	• Services provided to MSM with special focus on facility-based intervention	Gerard Belimac/ Jerome Castro
	Questions and answers	
15:30–15:45	*Coffee/Tea break*	
15:45–17:00	• HIV prevention using MSM networks	Nou Vannary
	• The benefits and challenges of creating and sustaining a regional network to support and enhance the provision of HIV/AIDS prevention, care and treatment services for MSM and TG	Kevin Frost
	Questions and answers	
17:00–17:15	Conclusion of Day 1 and wrap-up	Chairperson
18:30	*Welcome Reception*	

Day 2 – Thursday, 19 February

09:00–10:15	**Comprehensive package of interventions for the prevention, treatment, care and support of HIV/AIDS and STI for MSM, TG and their partners**	
	• Introduction to Asia Pacific Coalition on Male Sexual Health (APCOM)	Shivananda Khan
	• Overview on AusAID's scoping mission	David Lowe
	• Priority interventions for prevention and treatment of HIV and other STIs – WHO HIV/AIDS Department Publications from August 2008 – The MSM component	Antonio Gerbase
	• Priority interventions for the prevention and treatment of HIV and other STIs – the package proposed at the Global HIV/AIDS MSM meeting in Geneva	Ying-Ru Lo
	Questions and answers	
10:15–10:30	*Coffee/Tea break*	
10:30–12:30	• Access to the minimal package services in Thailand	Philippe Girault

	• Best practices and lessons learned from existing models of Comprehensive HIV prevention and care for MSM and TG within the Asia–Pacific region	Kevin Frost
	• Rising HIV epidemic among MSM and TG in Hong Kong (China) and its response	Ka-hing Wong
	Questions and answers	
12:30–14:30	*Lunch*	
14:00–15:00	**Key actions and recommendations for follow up at regional and country levels (Group work)**	
	• Group 1: Strategic information including gaps, data collection and utilization	Jan van Wijngaarden
	• Group 2: Comprehensive package of services for MSM, TG and their partners	Fabio Mesquita
	• Group 3: Policy and advocacy at central level to support the implementation of programmes for MSM, TGs and their partners	Edmund Settle
	• Group 4: MSM work in China and Hong Kong (China)	Zhao Pengfei
15:00–15:15	*Coffee/Tea break*	
15:15–17:00	Continuation of group work	

Day 3 – Friday, 20 February

09:00–10:15	Feedback from the group work and discussion
10:15–10:30	*Coffee/Tea break*
10:30–12:00	Plenary discussion – draft conclusions and recommendations
12:00	Closing

ANNEX 2

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ANNEX 3

IMPROVING THE ACCESSIBILITY OF HIV AND STI SERVICES FOR MSM AND TG: ISSUES TO BE CONSIDERED

Issue	Examples of successful interventions
• Many MSM still don't understand how knowing their HIV status will benefit them	• Include positive "knowledge of status" messages in outreach services • Negotiate clear pathways to treatment, care and support for HIV-positive MSM
• Many MSM diagnosed as being HIV-positive in isolated VCT services are lost to follow up	• Locate the VCT within other community support services • Set up MSM HIV support groups
• Fear, stigma, isolation and lack of knowledge keep many MSM away from HIV testing services	• Have a community VCT (located in MSM CBOs) • Have MSM on the staff in public VCT clinics to increase the use of these services by MSM • Promote trust and reduce fear by providing anonymous testing for MSM
• MSM are reluctant to use public STI clinics – fear, stigma, shame, treated poorly by staff • This leads to self-treatment through pharmacies, quacks	• Provide STI services in MSM CBOs • Allocate MSM staff in public STI clinics • Train medical and nursing staff in the management of STIs among MSM
• Many MSM with HIV become invisible between the time they are diagnosed as being HIV-positive and developing illness	• Have MSM HIV support groups and CBOs • Follow a case management approach including – regular counselling – peer support – clinical monitoring – nutritional/vocational/social support
• Many HIV clinical services do not see their role in contributing to HIV prevention – they assume MSM prevention is done in the community	• Interchange staff between services – MSM CBO staff can provide prevention counselling in HIV clinics • Train clinical staff to carry out prevention support • Include sexuality/risk behaviour information in clinical intake assessment and case management

• Some MSM subpopulations (particularly TG, migrants, homeless MSM) have difficulty in accessing ART – lack of identity papers, deemed unreliable by health officials	• Provide specific treatment access programmes for particular subpopulations • Provide legal assistance to formalize identity papers, address discrimination • Train CBO health workers to address specific subpopulation issues and prejudices
• Lack of coordination between VCT, STI, HIV, TB, drug treatment services means that MSM must have the knowledge, courage and funds to find and access the services they need	• Bring one-stop shop services for MSM – all necessary services under one roof • MSM CBOs negotiate service by service for their constituents – provide staff training, priority referral cards and follow up • A continuum-of-care committee can be constituted to bring CBOs and services together to remove barriers
• Many MSM services and programmes remain “boutique” and “demonstration”services – lack government ownership or clear scale-up of models and strategies	• Advocacy by MSM CBOs for state-supported MSM services • Larger, stable MSM CBOs can mentor and train smaller emerging groups in other geographical areas • Specific services can be developed for harder-to-reach subpopulations (TG and MSM sex workers)